FY 2001 BUDGET AND PERFORMANCE REQUIREMENTS
ADDENDUM 2

OCTOBER 13, 2000

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Claims Payment (Carrier)

The following is a list of major activities related to Claims Payment. This should not be construed as an all-inclusive list of tasks. Carriers should continue to budget for all activities currently performed. If there is a significant activity that you perform that is not listed below please add a statement in your narrative justification describing that activity.

CLAIMS PAYMENT ONGOING - Activity Code 11001

The claims payment BPR for FY 2001 relates to HCFA's goal to promote sound financial management and fiscal integrity of HCFA programs.

Receipt, Conversion and Control

Include all costs related to receipt, opening, sorting, microfilming, controlling, batching, activating and entering/keying of Title XVIII claims into the contractors claims processing system. (Do not include mailroom or control costs associated with the receipt of medical information or MSP development.)

- Receiving Non-Electronic Claims (i.e., Hard Copy, Fax and OCR Claims)-- The process includes the following actions: receiving, opening and sorting mail; opening envelopes; extracting claims; sorting claims by type; stamping control numbers; microfilming claims and attachments; copying microfilm; checking claims for missing data elements; batching, controlling, and data entry activities for claims/adjustments; and scanning or imaging claims.

- Receiving Electronic Media Claims -- The process includes the following actions: controlling claims received via electronic media; providing ongoing support to electronic billers and their system vendors or billing agents as needed to enable them to maintain their billing software and submit electronic billing data in the proper format; scheduling claims received for processing and storage or returning to sender; acknowledging electronic claim receipts; and returning claims failing front-end edits to the provider for correction and resubmission.

- Maintenance of Necessary Support Systems -- Include the costs of maintenance of systems for electronic data interchange (EDI) activities and transactions other than EMC. Charge this cost and that of maintenance of systems to support EDI requirements, including related telephone lines and telecommunication hardware to EDP, and allocate to all appropriate functions. Where it is possible to allocate all of the costs for some subset of EDP (e.g., on-line direct data entry costs) allocate them to the identified function. Refer to MCM, Part 3, Sections 3023-3025.

Notices of Utilization (NOU)/Explanation of Medicare Benefits/Medicare Summary Notices (EOMB)

- Program Memorandum Intermediaries/Carriers, Transmittal No. AB-99-3, Dated February 1999, Change Request 756 replaces all previous instructions and requires contractors to send EOMBs/MSNs in **all** instances except for the following claim types: Laboratory, Demonstrations, Exact Duplicates, and Statistical Adjustments. These four types of claims still require suppression of notices.

Claims/Adjustment Editing

Include all costs related to routine editing of claims and adjustment actions.

This process includes the following actions: returning claims failing front-end edits to the provider for correction and resubmission (Do not include edits performed for specialized purposes such as Medical Review/Utilization Review and Medicare Secondary Payer.); header and line editing/auditing for data accuracy and consistency (e.g., duplicate checking, provider and beneficiary eligibility, validity of provider ID, and validity of diagnostic and procedure coding information); and resolution of online edits/audits that do not require development.

Claims Resolution

Include the costs of requesting information (other than medical or MSP) to complete claims adjudication.

- Return/reject/development--Most of these claims are returned and rejected; however, with those that are developed, include the cost of gathering missing, erroneous, or incomplete data, necessitating telephone or correspondence development with physicians, beneficiaries, suppliers, or providers to obtain information before further processing.

  NOTE: If employing direct on-line entry techniques to enter a claim into the system, charge this cost and that of maintenance of on-line systems, related telephone lines and telecommunications hardware to EDP and allocate it to all appropriate functions. Where it is possible to allocate all of the costs for some subset of EDP costs (e.g., on-line direct data entry costs), allocate them to the identified function.

Processing

Include only costs related to routine claims/adjustment processing. This process includes the following actions: re-entry of corrected/developed claims/adjustment actions to allow further processing of the claim/adjustment; claims processing application programs mandated by HCFA instructions are utilized; capture on-line data; spool on-line data to storage media, and schedule on-line data for processing; directing claim and adjustment output to appropriate storage media; scheduling finalized claims for processing, posting /updating internal records with processed claim/adjustment information.

Common Working File (CWF)

Include costs for activities required for complete and accurate storage, preparation, and processing of data sent to and received from CWF.

Payments and Remittance

Include the costs of producing a check or EFT payment and remittance advice (refer to MCM, Part 3, Sections 3021-3025 and 7030) and Medicare Summary Notice.

Paper/Manual Data Interchanges

Plan to modify the standard format for paper remittance notices and to distribute an updated PC-Print once a year. Modifications in the electronic standard for remittance advice transactions could require accompanying changes in the standard paper format and the PC-Print. (See EDI section of BPRs and MCM, Part 3, Section 7030; standard paper format specifications are released in tandem with electronic format version specifications or manual instructions when a paper format change is needed. Issue revised PC-Print software as appropriate in conjunction with the electronic system changes that underlie the need for the change.)

In FY 2001, we expect that contractors will make system changes for implementation of the national transaction standards for EDI as required under the Health Insurance Portability and Accountability Act (HIPAA) of 1996. Although not currently anticipated, some revision could also be needed to the paper remittance format at that time.

Claims Service

Include all costs related to:

- Filing, removing, updating, refiling and general maintenance of electronic and paper claim/adjustment files.
- AHelp desk≅ personnel as made available for all above tasks as necessary.

Coordination of Benefits

Contractors are to continue the solicitation of agreements for the purpose of crossing paid claims data to other health care insurers. Contractors are to continue to cross over Medicare paid claims data to their existing trading partners, and to collect the fees in accordance with MCM, Section 4601.

Fee Schedule

Include the cost of maintaining and updating fee schedules, which may include systems changes.

Quality Control

Include all costs related to routine quality control techniques used by management to measure the competency and performance of claims processing personnel.

Electronic Data Interchange (EDI) Support

EDI supports a variety of the functions listed above. Also, note that some work listed in this EDI section represents work that should be construed as discretionary, which Amay≅ be adopted as a best practice if cost effective.

HCFA defines EDI as the fully automated transfer of data between a biller (provider or agent) and Medicare for billing, remittance advice, eligibility query/response, claims status query/response, claims development request/response, and other purposes in lieu of an otherwise manual claims processing related activity, or between Medicare and a bank for electronic funds transfer or remittance advice, or between Medicare and another payer for coordination of benefits. To be considered EDI for workload reporting purposes, data must be transferred in an automated fashion, without the need for routine manual intervention. EDI requirements are defined in Medicare Carriers Manual (MCM), Part 3, Sections 3021-3025, MCM, Part 2, Section 5240, and in the EDI standard format implementation guides as issued by HCFA and published on the HCFA web page www.hcfa.gov/medicare/edi/edi.htm or in implementation guides published at www.wpc-edi.com which HCFA directs its contractors to implement in compliance with HIPAA.

Discrete EDI activities include:

Establish and support EDI connections as required for Medicare.

a. Conduct outreach activities with providers to educate them on and expand their use of the EDI transactions supported by Medicare. Outreach should include training for provider staff in submission of claims electronically using Medicare billing software (if selected by the provider) and use of PC-Print software, provision of information on potential EDI vendors (through maintenance of an electronic billing Vendors Directory and distribution of copies of the directory on request), and information on and the advantages of use of each of the EDI standards supported by Medicare.

   (NOTE: Questions were raised as to which outreach costs should be applied to the Provider Education and Training (PET) function and which to EDI/Claims Processing. The Program Management Provider Education and Training (PM-PET) function covers the education of groups of providers, rather than contacts with individual providers. PM-PET costs would include newsletters, and classes or outreach to providers and their staff on Medicare coverage, billing and benefits of EDI in general, but would not cover costs to interact with individual providers to establish their connectivity for EDI, to resolve problems maintaining that connectivity, to exchange EDI transactions, to otherwise interact individually with a provider on EDI-related activities, or to interact with vendors/clearinghouses for the transfer of EDI transactions. Although

EDI-specific support is generally supplied by EDI staff, rather than PET staff, that may vary by contractor. To the extent that PET staff of a particular contractor may also furnish specialized EDI support, the proportion of their time spent furnishing EDI support to individual providers should be charged to Claims Payment.)

b. Acquire and maintain telecommunication protocols and lines, and software and hardware for the receipt and issuance of electronically transmitted batch transactions in a secure manner, and hardware for the processing of magnetic tapes delivered by trading partners.

(NOTE: Reference to Alines≅ here does not refer to 800 lines at one time maintained for participating physicians and suppliers. As used here, >lines≅ refers to maintenance of adequate telephone lines so you have the capability to receive and send the quantity of EDI traffic resulting from your agreements with your electronic trading partners.)

c. Prepare, maintain and distribute free Medicare electronic billing and PC-Print software to providers on request.

(NOTE: Carriers must furnish free/at cost Medicare billing software and PC-Print software to providers on request for pre-HIPAA claim and remittance advice versions, as well as for the HIPAA claim and remittance advice version when implemented. Pre-HIPAA versions of the PC-Print and billing software are included in Claims Payment. Since significant changes will need to be made for the HIPAA version of these software packages, the initial HIPAA version software is addressed in the PI section.)

d. Conduct system testing with electronic trading partners to assure compatibility between systems for successful exchange of data.

e. Obtain an EDI Enrollment Form from each provider prior to electronic transfer of data and issuance of system passwords/billing numbers to protect the security of transferred data.

f. Use the Medicare standard ASC X12 997 for automated confirmation of receipt of electronic X12 transactions. Use the Medicare standard flat-file functional acknowledgment for confirmation of receipt of electronic flat files. (See MCM, Part 3, Section 3023).

g. Edit data received from trading partners for compliance with system requirements and format specifications.

h. Route edit and exception messages, claim development messages and remittance advices automatically to electronic trading partners via direct transmission or via deposit to an electronic mailbox for downloading by a trading partner.

(NOTE: A Medicare carrier is responsible for the cost of delivery of this information. Electronically, this includes the cost of generating the data, transmission to an electronic mailbox or direct to the biller=s computer, and the cost of the electronic mailbox where data may be stored pending downloading by the biller. A carrier is not responsible for the costs of data transportation between the mailbox and the biller.)

i. Maintain capability for submission of EDI transactions in batch and for batch correction of edits by electronic trading partners. ABatch≅ means the submission of data accumulated over a period of time which is processed sequentially by the receiver in a subsequent computer system run with the results of processing relayed back to the submitter after completion of that run.

+ As current system capabilities allow, a carrier may issue batch requests for and/or receive

structured claim attachments electronically. This is not required, and supplemental funding will not be provided to add this capability where it does not currently exist (prior to HCFA-directed implementation of the HIPAA attachment standard implementation guide, this is discretionary), but it is permitted as an EDI activity where the capability already exists. Separate funding will be provided for implementation of the HIPAA transaction for attachments as a Productivity Investment (PI) upon publication of the implementing regulation.

+ As current system capabilities and formats allow, a carrier may use online or fast batch processes for submission of claims, claims adjustments, attachments and correction of edits. AOnline≅ means interactive processing of data upon receipt, including interactive responses to edits intended to clarify the data, and immediate relaying of the results of the processing to the submitter. AFast batch≅ means the receipt of data accumulated over a period of time that is processed typically in less than a minute after receipt, for which the results of processing are relayed back to the submitter immediately upon completion of processing. Carriers are not required to maintain online or fast batch capability, and will not be funded to establish such capability where it does not already exist. This is considered a discretionary capability, but use of online and fast batch processes is permitted, where the capability already exists.

+ As current capabilities allow, a carrier may maintain batch capability for receipt of and response to claims status requests. Carriers are not required to have this capability and they will not be funded to add this capability where it does not already exist (prior to HCFA-directed implementation of the HIPAA standard implementation guide for claim status inquiries and responses, electronic claims status and response capability is considered a discretionary activity). However, carriers who may posses this capability are permitted to use it as an EDI activity.

j. Verify the validity of the EDI data received from electronic trading partners through selective audits and use of other verification tools.

k. Make skilled staff available to provide EDI support as needed to maintain connections with electronic trading partners.

l. Furnish providers and their clearinghouses/agents with at least 60 days advance notice of system changes that will impact the EDI transactions they send to or receive from Medicare. Depending on the extent of changes, issue notices or provide educational programs to facilitate implementation of the changes or new standards by your trading partners.

Retain, or be able to recreate, all electronic transactions that were used to process or adjust claims, update claims or provider history files, to issue remittance advices or electronic query responses, or to conduct any other transaction with a trading partner electronically in accordance with requirements in MCM, Part 2, Section 5404.

As carrier system capabilities allow, support electronic receipt of provider appeal requests. (As part of an appeals enhancement demonstration project, a small number of contractors were allowed to use local format for receipt of electronic appeal requests from providers. Although this project was not extended nationally, and no national electronic format exists for electronic appeal requests, those contractors who currently have this capability may continue to use it. Funding will not be provided to add this functionality where it does not already exist. This is a discretionary activity)

As carrier system capabilities and formats allow, support online or fast batch receipt of and response to EDI eligibility inquiries.

Retain statistics on EDI performance to support workload reporting and monitor the effectiveness of your EDI marketing activities. (NOTE: At the current time, this entails collection of EMC data for the monthly workload reports, but HCFA expects to expand CROWD reporting at some future date to add performance tracking for EFT, paper and electronic remittance advices, electronic eligibility queries and responses, and other EDI transactions. Carriers will be issued specific manual instructions and related funding as a PI, when such changes are made.)

The shared system maintainer and carriers must make system changes as needed to update each of the already implemented and HCFA-supported standard electronic formats, including for COB, claims, remittance advices and eligibility inquiries and responses once a year if so directed by HCFA.

a. Implement new reason codes, remark codes, HCPCS, and other code additions/changes issued during the year for use in the supported EDI formats.

Maintain quality assurance procedures to validate the effectiveness and accuracy of the EDI process.

a. Utilize EDI compliance software (also referred to as Standards Enforcement Software [SES]) when issued by HCFA for self-diagnosis and correction if necessary, in conjunction with your shared system, of your ASC X12 EDI programming.

b. Use self-maintained quality assurance tools for validation of other EDI transactions you may support in a local format which have not been nationally standardized or implemented by Medicare

Carriers and/or their shared system may need to enhance system memory as necessary in preparation for implementation of the alternate reversal method in the ASC X12 835 version 4010 for reporting of electronic remittance advice adjustment data. Version 4010 requires that adjustment data on remittance advices be reported under the Apreferred method≅, which requires full reversal and correction effective with the HIPAA version. We have been informed that some carriers/shared system may require additional memory to comply. Version 4010 of the 835 may be reviewed by selecting the HIPAA implementation guides at www.wpc-edi.com for further information on this requirement.

EDI costs do not include: the use of fax or optical character recognition (OCR) technology for the receipt of claims data, attachments, inquiries, or other transactions (although these costs may be attributable to receipt of data classified as hard copy); purchase, operation, mapping to or maintenance of software for the use of data received in a non-standard format; purchase of claims data from a clearinghouse or other source (except as part of COB when Medicare is the secondary payer); any share of the costs of a clearinghouse or other service organization established by an umbrella organization which owns or has authority over a Medicare carrier; or any costs involved with activities not specifically permitted by HCFA as related to EDI. Medicare cannot subsidize the costs of a potentially for profit entity operated or controlled by a carrier=s parent organization, just as it cannot subsidize the costs of clearinghouses that are not associated with a Medicare contractor.

A Medicare carrier=s reimbursement is limited to reasonable, allowable, and allocable costs in performance of the functions specified in its Medicare contract. Medicare may not pay for more than its pro-rata share of the indirect, general and administrative costs related to overhead shared with any parent company of the carrier.

By virtue of its relationship with or control of a Medicare carrier, a carrier=s parent company has no inherent right for itself or for any clearinghouse or other entity which it also controls to read, use or manipulate data received that is intended solely for Medicare use. A clearinghouse owned or controlled by a parent company is subject to the same restrictions on use of Medicare data that apply to any other clearinghouse. No clearinghouse may retain Medicare data for longer than required to successfully reformulate that data into a format acceptable by Medicare or another payer or to transmit that data to the correct payer. Nor may a clearinghouse sell or share data received for or from Medicare (except insofar as required for COB), beyond general statistical data on the number and types of records received, generate reports involving the content of that data, or use the data for any purpose not specifically permitted by Medicare.

Security

Carriers are required to adhere to the systems security policy/procedure outline in the Medicare Carriers Manual, Part II, Sections 5135-5139 and the Internal Revenue Service=s Tax Information Security Guidelines (IRS Safeguard Activity Procedures). The policy is designed to protect Medicare assets, Medicare data and systems at the contractor sites. Activities include but are not limited to establishing and maintaining systems security controls for the data centers, LANs, WANs, systems software, application programs, operating systems, and data storage facilities.

The contractors shall establish and maintain a Contingency Plan and Exercise on an annual basis. (MCM, Section 5137{f}). The survival of the Medicare Program is contingent upon the development of comprehensive emergency procedures. In the event of a crisis, the emergency procedures must be activated promptly and at short notice in order to minimize the impact of a disruption to the Contractor=s critical business functions.

The contractors shall establish and maintain a risk analysis every three years (MCM, Section 5137{e}). The risk analysis shall consider scenarios that could cause an impact on the contractor Medicare assets. The contractor must describe the Medicare operations, identify vulnerabilities to the Medicare operation and determine the cost measures necessary to mitigate vulnerabilities.

Security (DMERCs and CWF Hosts)

HCFA=s entity wide systems security model requires an equal consideration of BPRs for all Medicare Contractors; the DMERCs, the Standard Systems, and the CWF Host Sites. Both Medicare Systems Security Manuals (MIM, Sections 2972-2976 and MCM, Sections 5135-5139), and the Internal Revenue Service=s Tax Information Security Guidelines (IRS Safeguard Activity Procedures) requires the contractors to adhere to federal systems security policy. The policy is designed to protect Medicare assets, Medicare data and systems at the contractor sites. Activities include but are not limited to establishing and maintaining systems security controls for the data centers, LANs, WANs, systems software, application programs, operating systems, and data storage facilities.

The contractors shall establish and maintain a Contingency Plan and Exercise on an annual basis. (MIM, Section 2974 {f} and MCM, Section 5137 {f}). The survival of the Medicare Program is contingent upon the development of comprehensive emergency procedures. In the event of a crisis, the emergency procedures must be activated promptly and at short notice in order to minimize the impact of a disruption to the Contractor=s critical business functions.

The contractors shall establish and maintain a risk analysis every three years (MIM, Section 2974 {e} and MCM, Section 5137 {e}). The risk analysis shall consider scenarios that could cause an impact on the contractor Medicare assets. The contractor must describe the Medicare operations, identify vulnerabilities to the Medicare operation and determine the cost measures necessary to mitigate vulnerabilities.

Workload

Claims Workload, Activity Code 11001, (Workload 1 in CAFMII) is the cumulative number of claims processed as reported on Line 15 of the HCFA-1565, Total Column less the cumulative replicate claims as reported on Line 16, Total Column of the HCFA-1565.

PROVIDER/SUPPLIER ENROLLMENT (Activity Code 11006):

The Provider/Supplier Enrollment (PSE) Budget and Performance Requirements (BPRs) reflect the objectives and priorities of the Medicare Program. The goals of PSE are to properly enroll all providers/suppliers through the use of the Medicare General Enrollment Application, Form HCFA-855, and to:

o Ensure that Medicare billing privileges are granted to and retained by only those individuals and

organizations that have enrolled in the Medicare program, have had their information verified through the enrollment process and they are found to be responsible and accountable business partners; and

o Ensure that health care security for beneficiaries is maintained by demonstrating that the enrolled providers/suppliers are qualified to provide medical care services or items to our beneficiaries by meeting all applicable requirements and standards for their profession.

The PSE BPRs form the basis of the Contractor Performance Evaluation (CPE) for PSE units. Carrier budget requests must ensure implementation of all PSE program requirements in the Carrier Manual, Sections 1000-1030 (or the appropriate Program Integrity Manual section) and pertinent Program Memoranda in addition to those specified in this document.

Staffing Requirements

Carriers must assign staff to the PSE enrollment function commensurate with the enrollment workload. Those employees must have received formal training on enrollment requirements, procedures and techniques. The PSE staff must ensure enrollment actions are completed accurately and within specified time frames, according to the standards set by HCFA. The interaction with the provider/supplier community on PSE issue is to be handled knowledgeably, professionally, and courteously.

Monthly interaction and coordination among the contractor□s fraud unit, medical review unit, provider enrollment unit, and provider relations unit are essential in determining the appropriate actions to be taken to resolve Program Integrity issues. The goal of this coordinated effort is for all parties to work as an informed team to arrive at an agreed upon resolution of outstanding Program Integrity concerns/issues. Additionally, maintain a dialogue and exchange of information with the PSE counterparts at the other intermediaries and/or carriers servicing the same State.

Ongoing Provider/Supplier Enrollment Activities

Carriers must complete all PSE actions within the specified time frames and in compliance with the operational standards contained in the Medicare Carriers Manual (or appropriate Program Integrity Manual section) and Program Memoranda relevant to the process for enrolling providers and suppliers, such as verifying ownership, qualification, and all other pertinent data.

Report all costs associated with the following mandatory requirements:

- Attending annual PSE conference at HCFA Central Office by all essential staff, e.g., managers and personnel intimately involved in the PSE process;

- Maintaining up-to-date information on State and local licensing and accreditation requirements for each category of provider in your jurisdiction;

- Establishing/maintaining processes for getting timely license revocation information from State and local jurisdictions;

- Mailings related to PSE;

- Handling provider inquiries related to PSE in an efficient and timely manner. HCFA is installing a 1-800 line for providers to contact PSE staff or dedicated PSE customer service staff person to handle any provider questions, to include those about the Medicare Enrollment Form HCFA-855;

- All activities involved in receiving, controlling, reviewing, validating and processing the current PSE applications and supporting documents, including but not limited to:

    - coordination with State survey and certification agencies and HCFA Regional Offices on enrollment of Ambulatory Service Centers;

    - sharing information with other carriers and intermediaries gained during the enrollment process which might indicate the possible existence of a program integrity issue affecting another jurisdiction;

    - coordinating with other intermediary units regularly, and on an as needed basis, per the AStaffing Requirements≅ section;

    - verifying licensure and other information concerning the professional and business qualifications of the applicant as stipulated in program instructions and/or as determined by State and local requirements.

    - as part of the initial review of an application, to the maximum extent possible, utilize telephone contacts with the applicant to resolve discrepancies and/or request additional information. Such discrepancies include, but are not limited to, submitted Social Security Numbers (SSNs) and Employer Identification Numbers (EINs) emanating from data exchanged between HCFA, the Social Security Administration and the Internal Revenue Service. Written correspondence is expected if telephone contact cannot be accomplished or it is impractical to request the information verbally.

- establishing, administrating, and tracking an appeal process following HCFA requirements;

- verifying/validating PSE data related to the applicant and associated parties as listed on the Form HCFA-855 as required by the proposed PIG manual (1030) on provider enrollment;

- checking names and other identifying information against the OIG sanction/exclusion list, the GSA debarment list, the Healthcare Integrity and Protection Data Bank (HIP Data Bank) and the Fraud Identification Database (FID) to ensure that billing privileges are not granted or retained by individuals and entities on those lists in accordance with existing program instructions. This action must be accomplished by the carrier and not by a third party verification service;

- performing (or completing through contracted services) onsite visits to problematic categories of providers/suppliers and individual providers/suppliers determined necessary by the carrier or as required by HCFA. Include initial site visits to all applicants seeking to enroll as an IDTF unless a site visit has previously been accomplished;

- entering/updating provider/supplier data into the Provider Enrollment and Chain Ownership System (PECOS) when operational and continuing to input data into CROWD until PECOS is operational;

- entering/updating the provider/supplier data in the UPIN Registry;

IMPORTANT NOTE: THE HCFA-855 PROCESSING TIMES AND PERCENTAGES WILL NOT GO INTO EFFECT UNTIL THE REVISED HCFA-855 AND ITS INSTRUCTIONS, AS WELL AS THE REGULATION, ARE PUBLISHED. APRIL, 2001, IS THE PLANNED DATE FOR FINAL PUBLICATION.

- processing initial applications from receipt in the mailroom through the final decision 90 percent of the time within 60 days or sooner and 99 percent of the time within 120 days;

- processing HCFA-855Rs within 30 days of request unless the physician/entity (who is eligible to receive the reassigned benefits) has to enroll for the first time;

- processing requests for change applications from receipt in the mailroom through the requested change updated in the contractor's system and UPIN Registry 90 percent of the time within 30 days or sooner and 99 percent of the time within 45 days;

- accomplishing a 20 percent national reduction in application return rates when returned for additional information;

- flagging the applicant=s record to allow for updating after the final decision is made on a pending adverse legal action (see FID). Flag providers/suppliers who have had or are experiencing bankruptcies found from another source. Determine if applicant, owners, or managing/directing employees have entered into bankruptcy or unrecouped overpayment situations. If found, refer to the Fraud Unit for further instructions;

- on-going review of PSE files to allow for the timely deactivations of provider numbers/billing privileges where the provider fails to meet program instruction requirements, including the deactivation of numbers for providers/suppliers that have not billed the Medicare program for ***four***

consecutive quarters;

- generating letters to providers/suppliers informing them that their billing number was deactivated and that they must attest that their enrollment file is current and correct before they are allowed to submit claims;

- on-going review of PSE files, or the addition of an edit, to capture when a provider/supplier exceeds five different individual reassignments and contacting the provider/supplier to verify that all reassignments are still current and legitimate;

- reviewing and investigating, where appropriate, billing agency agreements and provider/supplier reassignments of Medicare payments to ensure full compliance with operational guidelines. Include any ongoing work associated with special reassignment projects.

- Maintaining PSE information on the contractor=s company website to include, at a minimum, any additional information not included on the HCFA web site that the provider/supplier requires; and

- Enrolling any managed care organization/plan that desires to bill under fee-for-service for services designated in section 7065 of the Medicare Carriers Manual. However, if the managed care organization/plan is Medicare + Choice, it will be enrolled using the specified sections of the Form HCFA-855 as detailed in the proposed PIG manual (1030) for provider enrollment, and can be assigned billing numbers to allow for fee-for-service payments. If the managed care organization/plan is not Medicare + Choice, then it will enroll like any multi-specialty group or clinic and are required to complete the entire Form HCFA-855 and go through the complete verification process. Physician and non-physician practitioners who see these beneficiaries must also be enrolled in accordance with Medicare provider enrollment instructions.

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PROGRAM MANAGEMENT
Addendum 2

Appeals/Reviews (Carrier)

The Appeals & Hearings BPRs are instrumental in ensuring that an appellant's due process rights are protected under the Medicare program. Our BPRs make sure that the activities of our contractors are focused on meeting their primary functions.

Carrier appeals activities include the following:

Part B Telephone Reviews (Activity Code 12005)

- Receipt and control of review request from date of initial call request.
- These reviews are intended to replace standard reviews where there is the expectation that it can be carried out more expeditiously and/or it provides an easier burden on the appellant. When there would appear to be a need for a significant amount of either routine or complex documentation, or where the appellant would benefit from a more in-depth process, it might be appropriate to carry out the standard review process.
- Effectuation of the determination, as appropriate.

Workload

Part B Telephone Reviews workload (Workload 1 in CAFMII) is the cumulative number of claims as reported on the Form HCFA-2590, Line 7, Telephone Reviews Column.

Part B (Non-Telephone) Reviews - Section 1842(b)(2)(B) of the Social Security (Activity Code 12006)

- Receipt and control of review request. For purposes of meeting timely processing requirements, carriers must control receipt of review requests based on the date of receipt in the corporate mailroom.
- Conduct of review. At least 95 percent of Part B reviews must be completed within 45 days.
- Effectuation of the determination, as appropriate.

Workload

Part B Reviews (Non-Telephone) workload (Workload 1 in CAFMII) is the cumulative number of claims as reported on the HCFA-2590, Line 7, Reviews Column, less Line 7, Telephone Reviews column. Enter the cumulative number of cases as reported on the Form HCFA-2590, Line 22, Total Column in Workload 2 in CAFM II.

Part B Fair Hearings (Activity Code 12003)

- Receipt and control of hearing request. For purposes of meeting timely processing requirements, carriers must control receipt of hearing requests based on the date of receipt in the corporate mailroom.

- Conduct of hearing. A least 90 percent of Part B hearings must be completed within 120 days.

- Effectuation of the decision, as appropriate.

Workload

Part B Fair Hearing workload (Workload 1 in CAFMII) is the cumulative number of claims as reported on the Form HCFA-2590, Line 7, Hearings Column. Enter the cumulative number of cases as reported on the Form HCFA-2590, Line 32, Total Column in Workload 2 in CAFM II.

Part B ALJ Hearings - MCM ∋12027 and MCM ∋12028 (Activity Code 12004)

- Receipt of hearing request. Carriers must control receipt of ALJ hearing requests based on the date of receipt in the corporate mailroom.

- Case file assembly and forwarding. Carriers must forward requests and appropriate files together to SSA=s Office of Hearings and Appeals within 21 calendar days of receipt.

- Review of the ALJ=s decision.

- Effectuation of the ALJ decision.

    - In the case of an ALJ decision favorable to the appellant (from which an appeal is unlikely) and on which HCFA has not referred to the DAB for own motion review (Agency Referral), effectuation should be completed within 30 days of receipt of the ALJ decision**.**

    - In the case of an ALJ decision unfavorable to the appellant (from which an appeal may be likely) and on which HCFA has not referred to the DAB for own motion review (Agency Referral), effectuation should be completed within 30 days after the time limit for the appellant to ask the Departmental Appeals Board (DAB) to assume jurisdiction passes (appellants have 60 days from the date of the ALJ decision to ask the DAB to review).

    - In the case of an ALJ decision either favorable or unfavorable to an appellant and on which HCFA has referred to the DAB for own motion review (Agency Referral), the carrier is not to effectuate until advised by the Regional Office. Once the RO provides instruction to effectuate, the carrier is to complete the effectuation within 30 days.

- As necessary, submit recommended Agency Referral (formerly Protest) and case file(s) to the designated HCFA Regional Office within 30 days of the date of the ALJ's decision, (RO must get agency referral to the DAB by the 40th day).

- Responding to Departmental Appeals Board (DAB) Requests for ALJ Case Files.

  As of May 1, 2000, Empire Blue Cross will be holding for 120 days all ALJ dismissals and decisions that are totally unfavorable to an appellant. When an appellant requests a DAB review, the DAB will request that Empire forward the case as directed. Where appellants do not request DAB review, Empire will forward the case file, after the120 day period, to the appropriate contractor. With this new system in place, it is expected that DAB requests for case files from contractors will be greatly reduced for actions that take place subsequent to May 1, 2000. There still will be situations, however, where contractors will be required to provide case files to the DAB (e.g., for actions occurring prior to May 1, 2000).

- After the carrier receives an ALJ decision/dismissal and case file, they must review the ALJ's decision, effectuate (as necessary), and then file the case file (based on applicable records retention requirements).

- The carrier should maintain the case file in the exact order, manner, etc., as sent by the ALJ and should not make any marks or write on any documents contained in the case file. The case file is to be filed in a manner that allows the contractor to retrieve it based on any of the following indicators: Docket Number, Beneficiary HIC number, month of ALJs decision, Provider/Supplier number.

- The carrier should maintain a log of all requests made by the DAB for case files. The carrier is to note the date the request was received, the manner in which the request was made (phone, fax, e-mail, etc.), the name of the contact at DAB making the request, the identifying information that the DAB provided in support of their request, and the disposition by the carrier of the request.

- When the carrier locates the case file(s) that the DAB has requested, they are to forward the case file to the DAB, at the address provided by the DAB, within 21 calendar days of the request for case file. The case file is to be sent to the DAB in the exact order in which it was returned by the ALJ to HCFA. The original case file (not a copy) with no alterations (deletions, additions or changes) is to be sent. The carrier must log in the date the case file was forwarded to the DAB.

- If the carrier is unable to locate a requested case file, they are to notify the DAB immediately, in writing, that either:

a. the carrier is not the owner of that case file; or,

b. the carrier was not given sufficient information to allow for identification of the case file.

In either a. or b., the carrier must notify the DAB in writing within 14 calendar days, and the carrier must also notify, in writing, their RO appeals contact.

Workload

Part B ALJ Hearings workload (Workload 1 in CAFM II) is the cumulative number of claims as reported on the Form HCFA-2590, Line 45, Total Column. Enter the cumulative number of referrals made to the DAB in Workload 2 in CAFM II.

Part B ALJ Orientation Sessions

In FY 2001, HCFA will consolidate and conduct ALJ training and orientation sessions. This will eliminate all contractor requirements to develop and conduct ALJ training and orientation sessions. Contractors should not perform ALJ outreach, training or orientation sessions in FY 2001. If you receive request for ALJ outreach, training or orientation sessions from the Social Security Administration or from an ALJ, please notify your regional office.

Carriers should send an electronic and/or hardcopy copy of any ALJ training materials developed or used within the last 12 months to the following address:

Health Care Financing Administration
Division of Appeals
7500 Security Boulevard
Mailstop S1-05-06
Baltimore, Maryland 21244

Continuous Quality Improvement Program

HCFA is eliminating the requirements under continuous quality improvement. This change will eliminate all requirements to develop, implement, perform, or report on analysis used to find and reduce unnecessary appeals.

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Inquiries (Carrier)

NOTE: BENEFICIARY AND PROVIDER INQUIRY ACTIVITIES ARE SHOWN SEPARATELY IN THESE BPRS.

BENEFICIARY INQUIRIES

In keeping with our FY 2000 Beneficiary efforts, we are maintaining our pursuit of HCFA's strategic plan goal of becoming a customer-centered organization. HCFA is focusing on providing improved service to all customers, including Medicare beneficiaries. The FY 2001 Carrier Beneficiary Inquiry BPRs are designed to encompass HCFA's Strategic Plan and facilitate improving customer service. The FY 2001 BPRs continue to reflect the Agency's commitment to the Government Performance and Results Act of 1993, the Chief Financial Officers Act of 1990, and the Government Management Reform Act of 1994. HCFA requests that each Carrier prioritize its workload in such a manner to ensure that funding is allocated to accomplish the priority goals of the listed activities. HCFA expects that each Carrier will continue to prioritize its inquiry workloads in the following sequential manner:

1) Telephone Inquiries (including Quality Call Monitoring)
2) Written Inquiries,
3) Walk-in Inquiries,
1) Beneficiary Outreach to improve Medicare customer service.

BENEFICIARY TELEPHONE INQUIRIES – (Activity Code 13005) - See Attachment 1 as well as the Telephone Customer Service Web Site https://www.hcfa.gov/medicare/callcenter**) for Definitions. NOTE: We are adding a new Budget Activity Code (13014) to breakout Beneficiary Quality Call Monitoring.**

The FY 2001 Budget and Performance Requirements for Telephone Inquiries are intended to further demonstrate HCFA's commitment to customer service by requiring that contractor budgets for telephone inquiries are based on key performance measures. The measures are designed to be representative of the life cycle experience of the caller from *Pre-Contact* or from call inception to *Post-Call* or after call wrap-up. The measures will allow HCFA to ensure that Carriers are providing **quality** customer service and that they are doing this **efficiently**.

The measures provide HCFA a complete picture of the operations associated with the contractor's handling of customer inquiries. The measures are balanced across quality, cost, and time in order to ensure that they reflect the agency's priorities, the contractor's operations, and acknowledge available resources. It is anticipated that all of the performance measures shown below can be captured using existing systems and infrastructure.

Standard definitions and detailed calculations for each of these measures have been developed and are provided as Attachment 1. The definitions and calculations are also posted on the Telephone Customer Service web site.

HCFA is currently testing Medicare Beneficiary Interactive Voice Response (IVR) scripts with the intent of implementing them at either selected or all call centers depending on the findings of the test. Each call center will be given ample notice of our intent to implement this script. No cost estimate will be necessary for the initial budget request.

During FY 2001, HCFA will be developing standardized training processes and materials for telephone Customer Service Representatives (CSRs).

HCFA will be expanding toll-free service for beneficiaries to all Part B Carriers. This will be accomplished through a new government-wide telephone contract negotiated by the General Services Administration. This telephone

service is known as Federal Technology Service (FTS) 2001. The costs associated with this toll-free service will be paid centrally by HCFA and should not be considered by contractors in future budget requests. However, Medicare Contractors will still be responsible for all other internal telecommunications costs and devices such as agent consoles, handsets, internal wiring & equipment (ACDs PBX, etc.) and any local or outbound telephone services and line charges.

Any toll-free Medicare Beneficiary customer service number provided and paid for by HCFA must be printed on all beneficiary notices (MSN, EOMB, etc.), immediately upon activation. This toll-free number shall be prominently displayed so the reader will know whom to contact regarding the notice.

Carriers will no longer be responsible for publishing their Beneficiary 1-800 inbound telephone numbers in the local telephone books. HCFA will take care of publishing all Beneficiary telephone numbers in the appropriate telephone books.

Instructions:

All tasks related to this activity are mandatory and shall be reported to HCFA's web-based Customer Service Assessment and Management System (CSAMS) as required.

Required beneficiary performance measures are listed below.

Pre-Contact Measures

1. Report Total Calls Offered to the Beneficiary call center for the month, defined as the number of calls that reach the call center's telephone system, which can be split up according to trunk lines in instances where a call center is taking calls for Part A, B and other non-HCFA calls.

2. All systems related to inbound beneficiary calls to the center should be programmed to acknowledge each call within 20 seconds (4 rings) before an agent, IVR or Automated Call Distributor (ACD) prompt is reached. This measure will not be required to be reported, but must be substantiated when requested. (This was previously reported as Average Speed of Answer in CSAMS)

3. The monthly All Trunks Busy (ATB) Internal Rate shall average 10%. Any exceptions to this performance level should be annotated in the monthly report. For all toll free lines, the ATB external rate must be reported.

4. For callers choosing to talk with a Customer Service Representative (CSR), 97.5% or more telephone calls shall be answered within 120 seconds; with no less than 85% being answered within the first 60 seconds.

5. If callers encounter a temporary delay before a customer service representative is available, a recorded message will inform them of the delay. The message will also request that the beneficiary have certain information readily available (Medicare card) before speaking with the agent. During peak volume periods, the message shall indicate a preferred time to call.

   Note: IVRs should be programmed to provide callers with an after-hours message indicating normal business hours (It is not necessary to duplicate this message if the caller is informed of the normal business hours via the telephone system prior to being delivered to the IVR). If call centers have IVRs that allow the recording of messages after hours, this service should be eliminated no later

than September 30, 2000. The contractor should inform the Regional Office and the Director of Call Center Operations, CBS of the proposed date of this action.

Call Handling Measures

6. Report Call Abandonment Rate, which is the percentage of beneficiary calls that abandon their call from the ACD queue. This should be reported as three separate measures:

    1) Calls abandoned up to and including 60 seconds,
    2) Calls abandoned up to and including 120 seconds, and
    3) Calls abandoned after 120 seconds.

7. Report the monthly Average Speed of Answer. This is the amount of time that all calls waited before being connected to a CSR. It includes ringing, delay recorder(s) and music.

8. CSRs must identify themselves when answering a call, however the use of both first and last names in the greeting will be optional. In order to provide a unique identity for each CSR for accountability purposes, where a number of CSRs have the same first name, it is suggested that the CSRs also use the initial of their surname. If the caller specifically requests that a CSR identify himself/herself, the CSR should provide both first and last name. Where the personal safety of the CSR is an issue, call center management should permit the CSR to use an alias. This alias must be known for remote monitoring purposes. CSRs should also follow local procedures for escalating calls to supervisors or managers in situations where warranted.

9. Report monthly Average Talk Time (which includes any time the caller is placed on hold by the CSR), targeting call duration between 3 and 7 minutes (180-420 seconds).

10. Handle no less than 80% of calls to completion during the initial call – minimizing transfers, referrals and callbacks.

11. Track Call Center call handling productivity, calculated by the total calls handled divided by the total CSR FTEs in the center, setting a minimum performance objective of 1100 calls per FTE per month for Non-Medicare Customer Service Center (MCSC) call centers and 1000 calls per month for MCSC call centers. This should be accomplished by all call centers without sacrificing the quality of calls and with minimal referrals. MCSC call centers should take advantage of handling multiple issued calls (Part A, Part B, DME, etc.) without referral to ensure maximum utilization the MCSC desktop.

12. Report Occupancy Rate, the percent of time that CSRs spend in active call handling (i.e., on incoming calls, after call work or outbound calls).

Post-Call Measures

13. Report monthly Average After Call Work Time (wrap-time), which includes all the time that the CSR needs to complete all administrative work associated with call activity after the customer disconnects.

14. Report the status of those calls not resolved at first contact. Those calls should be reported as follows:

    1) Callbacks required (This number is based on calls received for the calendar month and represents the number requiring a callback as of the last workday of the month)

2) Callbacks closed within 2 workdays (This number is based on calls received for the calendar month and represents the number closed as of the last workday of the month)
3) Callbacks closed within 5 workdays (This number is based on calls received for the calendar month and represents the number closed as of the last workday of the month)
4) Callbacks pending over 20 workdays (The number represents all callbacks currently pending on the last workday of month)

Staffing

15. As needed, develop a corrective action plan to resolve deficient performance in the call center, and maintain results on file for regional office (RO) review.

16. Develop a proficiency test to be used for new CSRs and as needed for existing personnel. Target no less than an 80% first time pass rate for the proficiency test.

Diverse Populations

17. Maintain and operate a telephone device for the deaf such as TDD/TTY.

18. Maintain the ability to respond directly to telephone inquiries in both English and Spanish.

Interactive Voice Response Units (IVR)

With automated tools being available for improving customer service while simultaneously managing cost, emphasis must be placed on developing and implementing self-service capabilities through the utilization of Interactive Voice Response (IVRs) Units. To promote the usage of such service enhancing and cost effective technology, we have provided the following list of metrics for use in the area of IVR utilization.

Strategic Operations Performance

1. The contractor strives to increase the use of IVRs based upon lessons learned and best practices throughout HCFA and its partners.

2. Unless otherwise directed by HCFA, the IVR (or telephone system) offers the following information, but it is not limited to:

- Contractor Hours of Operations for inbound Medicare beneficiary CSR service announced to callers after the hours of CSR availability and during peak times when a caller may be waiting on hold;
- General Medicare program information;
- Specific information about claims in process and claims completed;
- General information about appeals rights, and action required of a beneficiary to exercise these rights; and
- A statement if additional evidence is needed to have a claim processed.

3. The contractor prints and distributes to Medicare beneficiaries upon request a readily understood IVR operating guide.

4. The IVR shall be available to beneficiaries from 6 a.m. to 10 p.m. in their local prevailing time Monday through Friday, and 6 a.m. to 6 p.m. on Weekends with allowances for claims processing system and

mainframe availability, as well as normal IVR and system maintenance. Contractors should identify the services which can be provided to beneficiaries during processing system unavailable time.

Call Handling Performance

5. The contractor updates the IVR scripts to address areas of beneficiary confusion as determined by their inquiry analysis program and HCFA best practices.

6. The beneficiary should have the ability to transfer to a CSR during operating hours and receive a message indicating operating hours when the call center is closed.

7. Report IVR Handle rate, which is the number of calls delivered to the IVR in which the beneficiary receives the information they require from the system.

Workload

Beneficiary Telephone Inquiries workload (Workload 1 in CAFMII) is the cumulative inquiries as reported on the HCFA-1565, Line 25, Beneficiary Column.

BENEFICIARY QUALITY CALL MONITORING – (Activity Code 13014; Previously reported in Activity Code 13005.)

1. Measure and report the quality of service continuously by employing the Quality Call Monitoring (QCM) Process developed for FY 2000.

    - Monitor an average of 9 calls per CSR per quarter for quality. Focus monitoring efforts on new or other at-risk CSRs who would have the greatest potential to benefit from any feedback while reducing the monitoring frequency on experienced CSRs who have demonstrated a less significant need to be monitored. Individual CSR data shall be analyzed regularly, areas needing improvement identified, and corrective action plans should be implemented and documented.
    - The sampling routine must ensure that CSRs are monitored at the beginning, middle and end of the month (ensuring that assessments are distributed throughout the week) and during morning and afternoon hours.
    - Participate in national and regional calibration sessions organized by HCFA.
    - Contractor call centers should conduct regular monthly calibration sessions.
    - The QCM reporting tools and format, as posted on the Web Site, must be used to collect monitoring results which will be reported monthly on CSAMS.

BENEFICIARY SATISFACTION SURVEY

Beginning October 1, 2000, HCFA will have an independent third party develop and implement a national Beneficiary Satisfaction Survey (BSS). This will eliminate all requirements to develop, implement or perform any local beneficiary satisfaction surveys at the contractor level including reporting survey results in CSAMS.

The results of the national survey will be shared quarterly with contractors. A system will be developed to inform contractors of any particularly low satisfaction situations within two to three business days following receipt of customer responses. Contractors will be required to take any necessary corrective action based on any negative feedback or low satisfaction indicators resulting from the national BSS.

WRITTEN INQUIRIES (Activity Code 13002)

- All written inquiries are to be processed in accordance with the guidelines provided in the Medicare Carrier Manual, Sections 5104, 5105 and 5106.

- All written inquiries are to be processed using a font size of 12 and a font style of Universal or Times New Roman or another similar style for ease of reading by the beneficiary.

- In FY 2001, every contractor will have the flexibility to respond to beneficiary written inquiries by phone within 45 business days. A report of contact should be developed for tracking purposes. The report of contact should include the following information: Beneficiaries name and address, telephone number, beneficiaries HICN, date of contact, internal inquiry control number, subject, summary of discussion, status, action required (if any) and the name of the customer service representative who handled the inquiry. Upon request send the beneficiary a copy of the report of contact that results from the telephone response. The report of contact should be retained in the same manner and timeframe as the current process for written responses. Use your discretion when identifying which written inquiries (i.e., beneficiary correspondence that represent simple questions) can be responded to by phone. Use the correspondence, which includes the requestor's telephone number or use the requestor's telephone number from internal records if more appropriate for telephone responses. If you cannot reach the requestor by phone, do not leave a message for the beneficiary to return the call. A written response should be developed within 45 calendar days from the incoming inquiry.

  Any E-mail inquiry received can be responded to by E-mail. Since E-mail represents official correspondence with the public, it is paramount that carriers use sound E-mail practices and proper etiquette when communicating electronically. Responses that are personal in nature (contain financial information, HIC#, etc.) cannot be answered by e-mail. Should any e-mail practices or etiquette problems be identified, they should be considered "potential problems" and be forwarded to Central Office, Customer and Teleservice Operations Group for further guidance. However, ensure that e-mail responses utilize the same guidelines that pertain to written inquiries (i.e., timeliness, accuracy, clarity, tone, comprehension, etc.)

- Medicare Carrier Instructions will be updated to reflect new changes.

Workload

Written Inquiries workload (Workload 1 in CAFMII) is the cumulative inquiries as reported on the HCFA-1565, Line 27, Total Column.

WALK-IN INQUIRIES (Activity Code 13003)

4) General – The interviewer should have the same records available as a telephone service representative to answer any questions regarding general program policy or specific claims related issues.

   If a beneficiary inquires about a denied or reduced claim, give him/her the same careful attention given during a hearing, i.e., the opportunity to understand the decision made and an explanation of any additional information which may be submitted when a review is sought. Make the same careful recording of the facts as for a telephone response, if it appears further contact or a review will be required.

5) Guidelines for Walk-In Service –

6) After contact with a receptionist, the inquirer may meet with a service representative.

7) Waiting room accommodations should provide seating.

8) Inquiries should be completed during the initial interview to the extent possible. However, telephone follow-up is permissible.

Workload

Walk-In Inquiries workload (Workload 1 in CAFMII) is the cumulative inquiries as reported on the HCFA-1565, Line 26, Total Column.

CUSTOMER SERVICE PLAN (Activity Code 13004)

In FY 2001, the Customer Service Plans (CSP) activities will be funded on a HCFA Regional consortia level. Each Regional consortium will determine how decisions on CSP activities will be requested, approved, managed and reported. Not all Medicare contractors will be required to perform CSP activities. Authorization for CSP activities will be provided to individual Medicare contractors by each HCFA Regional consortium on an as needed basis.

HCFA's initiatives in the CSP area in FY 2001 will include but are not limited to:

- Participate in the National Medicare Education Program.
- Support ongoing Medicare preventive services.
- Establish partnerships and meet with local and national coalitions and beneficiary counseling and assistance groups.
- Provide service to areas with high concentrations of non-English speaking populations and for special populations such as: blind, deaf, disabled and any other vulnerable population of Medicare beneficiaries.

Each Regional consortium will provide specific directions to the individual contractors prior to CSP activities performed by contractors.

PROVIDER INQUIRIES

In FY 2000, HCFA installed FTS2001 toll free lines to handle provider telephone inquiries. The new toll free lines and numbers delivered calls to the existing Carrier phone systems. **(Note: These are Medicare provider inquiry lines, not data lines for EDI connectivity.)** The costs associated with this toll-free service will be paid centrally by HCFA and should not be considered by contractors in future budget requests. However, Medicare Contractors will still be responsible for all other internal telecommunications costs and devices such as agent consoles, handsets, internal wiring & equipment (ACDs PBX, etc.) and any local or outbound telephone services and line charges. The transition to toll free provider telephone service reflects an increased focus on customer service for providers. To the extent feasible, provider inquiry standards will be compatible with beneficiary standards. Contractors shall meet the FY 2001 provider inquiry BPR standards no later than July 1, 2001.

In keeping with our FY 2000 Beneficiary efforts, we are maintaining our pursuit of HCFA's strategic plan goal of becoming a customer-centered organization. HCFA is focusing on providing improved service to all customers, including Medicare Providers. The FY 2001 Carrier Provider Inquiry BPRs are designed to encompass HCFA's Strategic Plan and facilitate improving customer service. The FY 2001 BPRs continue to reflect the Agency's commitment to the Government Performance and Results Act of 1993, the Chief Financial Officers Act of 1990, and the Government Management Reform Act of 1994. HCFA requests that each Carrier prioritize its workload in such a manner to ensure high quality service to all providers. HCFA expects that each Carrier will continue to prioritize its provider inquiry workloads in the following sequential manner:

9) Telephone Inquiries,
10) Written Inquiries,
11) Provider Outreach to improve Medicare customer service.

PROVIDER TELEPHONE INQUIRIES – (Activity Code 13006) – See Attachment 1 as well as the Telephone Customer Service Web Site (https://www.hcfa.gov/medicare/callcenter**) for Definitions (unless otherwise specified, Beneficiary and Provider definitions will be the same)**

The FY 2001 Budget and Performance Requirements for Telephone Inquiries are intended to further demonstrate HCFA's commitment to customer service by requiring that contractor budgets for telephone inquiries are based on key performance measures. The measures are designed to be representative of the life cycle experience of the caller from *Pre-Contact* or from call inception to *Post-Call* or after call wrap-up. The measures will allow HCFA to

ensure that Carriers are providing **quality** customer service and that they are doing this **efficiently**.

The measures provide HCFA a complete picture of the operations associated with the contractor's handling of customer inquiries. The measures are balanced across quality, cost, and time in order to ensure that they reflect the agency's priorities, the contractor's operations, and acknowledge available resources. To the extent possible, all of the performance measures shown below should be captured using existing systems and infrastructure already established for beneficiary inquiries. Contractors may also implement manual systems to capture and report required data to HCFA, if that is more cost efficient. Contractors shall report any limitations to their ability to capture and report provider telephone inquiry data to their regional office and to the Deputy Director of PEBEG (CHPP) no later than January 1, 2001. Instructions will be included in the April release that will ensure full compliance no later than July 1, 2001.

Standard definitions and detailed calculations for each of these measures have been developed and are provided as Attachment 1. The definitions and calculations are also posted on the Telephone Customer Service web site and unless otherwise specified, Provider telephone inquiries definitions and calculations will be the same as Beneficiary inquiries definitions and calculations.

During FY 2001, HCFA will be developing, testing and issuing standardized training processes and materials for provider telephone Customer Service Representatives (CSRs).

Instructions:

All provider telephone inquiries are to be processed in accordance with the guidelines shown below and will be reported using Activity Code 13006.

Required provider performance measures are listed below.

Pre-Contact Measures . (Note: All specified information must be captured and reported to HCFA on a monthly basis. This information may be captured manually, if necessary)

1. Capture Total Calls Offered to the provider call center for the month, defined as the number of calls that reach the call center's telephone system, which can be split up according to trunk lines in instances where a call center is taking calls for Part A, B and other non-HCFA calls.

2. All existing systems related to inbound provider calls to the center should be programmed to acknowledge each call within 20 seconds (4 rings) before an agent, IVR or Automated Call Distributor (ACD) prompt is reached. This measure will not be required to be reported, but must be substantiated when requested.

3. The monthly All Trunks Busy (ATB) Internal Rate shall average 10%. Any exceptions to this performance level should be reported to HCFA.

4. For callers choosing to talk with a Customer Service Representative (CSR), 97.5% or more telephone calls shall be answered within 120 seconds; with no less than 85% being answered within the first 60 seconds.

5. If callers encounter a temporary delay before a customer service representative is available, a recorded message will inform them of the delay. The message will also request that the provider have certain information readily available before speaking with the agent. During peak volume periods, the message shall indicate a preferred time to call.

Note: IVRs should be programmed to provide callers with an after-hours message indicating normal business hours (It is not necessary to duplicate this message if the caller is informed of the normal business hours via the telephone system prior to being delivered to the IVR).

Call Handling Measures (Note: All specified information must be captured and reported to HCFA on a monthly basis. This information may be captured manually, if necessary.)

6. Capture Call Abandonment Rate, which is the percentage of provider calls that abandon their call from the ACD queue. This should be reported as three separate measures:

    12) Calls abandoned up to and including 60 seconds,
    13) Calls abandoned up to and including 120 seconds, and
    14) Calls abandoned after 120 seconds.

7. Capture the monthly Average Speed of Answer. This is the amount of time that all calls waited before being connected to a CSR. It includes ringing, delay recorder(s) and music.

8. CSRs must identify themselves when answering a call, however the use of both first and last names in the greeting will be optional. In order to provide a unique identity for each CSR for accountability purposes, where a number of CSRs have the same first name, it is suggested that the CSRs also use the initial of their surname. If the caller specifically requests that a CSR identify himself/herself, the CSR should provide both first and last name. Where the personal safety of the CSR is an issue, call center management should permit the CSR to use an alias. This alias must be known for remote monitoring purposes. CSRs should also follow local procedures for escalating calls to supervisors or managers in situations where warranted.

9. Capture monthly Average Talk Time (which includes any time the caller is placed on hold by the CSR).

10. Handle no less than 80% of calls to completion during the initial call – minimizing transfers, referrals and callbacks.

11. Track Call Center call handling productivity, calculated by the total calls handled divided by the total CSR FTEs in the center.

12. Capture Occupancy Rate, the percent of time that CSRs spend in active call handling (i.e., on incoming calls, after call work or outbound calls).

Post-Call Measures (Note: All specified information must be captured and reported to HCFA on a monthly basis. This information may be captured manually, if necessary.)

13. Capture monthly Average After Call Work Time (wrap-time), which includes all the time that the CSR needs to complete all administrative work associated with call activity after the customer disconnects.

14. Report the status of those calls not resolved at first contact. Those calls should be reported as follows:

    5) Callbacks required (This number is based on calls received for the calendar month and represents the number requiring a callback as of the last workday of the month)

6) Callbacks closed within 2 workdays (This number is based on calls received for the calendar month and represents the number closed as of the last workday of the month)
7) Callbacks closed within 5 workdays (This number is based on calls received for the calendar month and represents the number closed as of the last workday of the month)
8) Callbacks pending over 20 workdays (The number represents all callbacks currently pending on the last workday of month)

Staffing

15. As needed, develop a corrective action plan to resolve deficient performance in the call center, and maintain results on file for regional office (RO) review.

16. Develop a proficiency test to be used for new CSRs and as needed for existing personnel. Target no less than an 80% first time pass rate for the proficiency test.

Interactive Voice Response Units (IVR)

With automated tools being available for improving customer service while simultaneously managing cost, emphasis must be placed on developing and implementing self-service capabilities through the utilization of Interactive Voice Response (IVRs) Units. To promote the usage of such service-enhancing and cost-effective technology, we have provided the following list of metrics for use in the area of IVR utilization.

Strategic Operations Performance

1. The contractor strives to increase the use of IVRs based upon lessons learned and best practices throughout HCFA and its partners.

2. The IVR offers the following information, but it is not limited to:

- Contractor Hours of Operations for inbound Medicare provider CSR service announced to callers after the hours of CSR availability and during peak times when a caller may be waiting on hold;
- General Medicare program information;
- Specific information about claims in process and claims completed;
- Information about appeals rights, and action required of a provider to exercise these rights; and
- Additional evidence needed to have a claim processed.

3. The contractor prints and distributes to Medicare providers upon request a readily understood IVR operating guide.

4. The IVR shall be available to providers from 6 a.m. to 10 p.m. in their local prevailing time Monday through Friday, and 6 a.m. to 6 p.m. on Weekends with allowances for normal claims processing system and mainframe availability, as well as normal IVR and system maintenance. Contractors should identify what services can be provided to providers during processing system unavailable time.

Call Handling Performance

5. The contractor updates the IVR scripts to address areas of provider confusion as determined by their inquiry analysis program and HCFA best practices.

6. The provider should have the ability to transfer to a CSR during operating hours and receive a message indicating operating hours when the call center is closed.

7. Capture IVR Handle rate, which is the number of calls delivered to the IVR in which the provider receives the information they require from the system.

Workload

Provider Telephone Inquires workload (Workload 1 in CAFMII) is the cumulative inquiries as reported on the HCFA-1565, Line 25, Provider Column.

PROVIDER QUALITY CALL MONITORING

1. Measure and report the quality of service continuously by employing the Quality Call Monitoring (QCM) Process developed for beneficiaries in FY 2000.

- Monitor an average of 9 calls per CSR per quarter for quality. Focus monitoring efforts on new or other at-risk CSRs who would have the greatest potential to benefit from any feedback while reducing the monitoring frequency on experienced CSRs who have demonstrated a less significant need to be monitored. Individual CSR data shall be analyzed regularly, areas needing improvement identified, and corrective action plans should be implemented and documented.
- The sampling routine must ensure that CSRs are monitored at the beginning, middle and end of the month (ensuring that assessments are distributed throughout the week) and during morning and afternoon hours.
- Participate in national and regional calibration sessions organized by HCFA.
- Contractor call centers should conduct regular monthly calibration sessions.

FY 2001 BUDGET AND PERFORMANCE REQUIREMENTS
PROGRAM MANAGEMENT
Addendum 2

Provider Education and Training (Carrier)

The Provider Education and Training (PET) Budget Performance Requirements (BPRs) initiatives for FY 2001 are based on HCFA=s goal of providing superior services to its customers and to promote the short and long term fiscal integrity of the Medicare Program. The FY 2001 PET activities are to be allocated between the Program Management (PM) and the Medicare Integrity Program (MIP) budgets.

PM-PET uses mass media, such as print and Internet, face to face instruction and dialog in classroom and meeting settings to meet the needs of Medicare providers for timely, accurate and understandable Medicare information. The methods used for instructional design, promotion and dissemination (and the share of resources committed to specific activities) should depend on the scope of the problems and need for education. This may involve policy as well as billing and system issues and are often determined based upon the frequency of inquiries and claim submission errors. PM-PET activities are, for the most part, not targeted to individual providers. PM-PET is designed to be more general in nature and must focus upon training and consulting for both new and current Medicare providers. The scope of PM-PET is to identify and address issues that are of concern to providers. The costs associated with the education and training of these groups of providers and organizations should be budgeted and charged to Activity Code 14001.

This list of activities is designed to improve service to Medicare beneficiaries and providers. Prudent management of your plans will be necessary to achieve our goals. Open lines of communication between you and your RO, as well as with beneficiaries, providers/suppliers and their organizations will be necessary to ensure that operating priorities are properly set and plan objectives are accomplished in a creative and cost effective manner.

SUPPORTING DOCUMENTATION FOR FISCAL YEAR 2001 BPR REQUEST

- If increased funding is requested for PM-PET in FY 2001, please provide additional justifications for any increases. At a minimum, this should include information pertaining to increases in the number of providers serviced, expansion of geographical territory, staff turnover, etc. Please provide details, by required item, concerning any additional monetary increases.

- These BPRs identify the work to be performed in FY 2001. The education and training may be performed using various media. The education and training activities are separated into three broad categories: (1) required (2) enhanced, and (2) discretionary. The cost of conducting these activities or any fees that are assessed on providers or suppliers must conform to the guidelines provided below.

- Explain how you plan to allocate costs between PM-PET and MIP-PET. Please keep in mind that any general seminars, conventions, or conferences which address fraud and abuse as well as other Medicare issues, the proportional share of the cost of a function to be allocated to PM-PET is equal to the percentage of time related to addressing other Medicare issues times the cost of the function. For example, the proportional share of the cost of a seminar to be allocated to PM-PET is equal to the percentage of the seminar related to addressing issues other than fraud and abuse multiplied by the cost of the seminar (e.g. if it costs $4,000 to arrange and conduct a seminar, containing 75 percent program and billing information and 25 percent fraud and abuse information, then the PM cost would be $4,000 multiplied by .75 or $3,000 and the remaining $1,000 would be charged to MIP-PET)

Fee Policy For Provider Education and Training Activities

Under Section 1816(a) and Section 1842(a)(3) of the Social Security Act HCFA directs Medicare contractors to develop and provide prescribed provider education and training activities which are included in their annual PET plans. In recent years, HCFA has made significant expansions in its provider education and training efforts, which extend beyond the basic statutory requirements. This expansion has been in response to major program changes provided in recent legislation and the need to facilitate greater receptivity by the provider/supplier communities to changes in the Medicare program.

In June of this year Medicare contractors were advised that it was inappropriate to charge providers a fee for education and training activities. Subsequent guidance will be provided shortly reinforcing this instruction for the Acore≅ provider education and training envisioned under the statute. These activities must be conducted within the funding levels provided contractors by HCFA in their NOBAs. However, charges may be assessed to recover the costs of training an materials that are in addition to these Acore≅ contractual obligations. The following categorizations provide examples that distinguish between provider education efforts considered to be statutorily mandated (provided at no-charge to providers) and those considered to be Asupplemental≅ or Aenhancements≅ for which a modest charge could be assessed. A third category of "discretionary" activities is also provided where the cost to providers must be fair and reasonable. Contractors must only use the revenues from these activities to cover the cost of provider education and training activities --- not to supplement other contractor activities.

A. Required Training/Education Activities (no- charge)

- Activities designed to educate new providers and suppliers in Medicare enrollment, coverage, reimbursement and billing requirements.
- Medicare provider/supplier bulletins.
- Training on significant Medicare program changes (for example, hospital outpatient prospective payment, home health prospective payment, consolidated billing, etc).
- Recruitment of new providers.
- Information concerning HCFA=s quarterly systems releases.
- Training on the electronic submission of claims.

B. Enhanced Training/Education Activities (modest charge not to exceed 10% of the cost of the training)

- Training/education activities not included in ≅A≅ above.
- Supplemental training focused on particular program areas.
- Participation in conferences sponsored by Medicare partners that did not result from recommendations from the PET Advisory Group.

C. Discretionary Activities (fair and reasonable cost)

- Individualized training requested by a provider/supplier.
- Training not included in the annual PET plan.
- Training provided at national conferences (or training conducted outside the contractor=s service area).
- Training videos.

- Presentations at Non-Medicare conferences.

- Light refreshments.

ELEMENTS OF PROVIDER /SUPPLIER SERVICE PLAN

All Carriers are instructed to develop a Provider/Supplier Service Plan (PSP) to support the requirements outlined below and submit it with your Budget Request. Your costs for developing the Provider/Supplier Service Plan should not exceed 15 percent of your total budget allocation. The PSP should detail, in chronological order, how each of the required PET activities will be conducted. (Please note the related requirements for provider/supplier services plan, as well as Activity 13006 Provider Telephone Inquiries.) With your PSP, provide to both Central Office (CO) and your Regional Office (RO), the name and phone number of your PSP coordinator. Plans sent to Central Office should be addressed to the Center for Health Plans and Providers, Division of Provider Education and Training, Mailstop C4-10-07, 7500 Security Boulevard, Baltimore, Maryland 21244.

REQUIRED PET ACTIVITIES

I. Inquiry and Data Analysis

A. Implementation and ongoing operation of a provider inquiry analysis program.
Maintain and update, on a monthly basis, a list of most frequently asked questions and areas of concern/confusion for providers. Problem areas as determined by claim submission errors must also be tallied and analyzed monthly. Outreach and educational efforts should be developed to address the needs of providers as those needs are made known by these initiatives. Educate providers on program/billing issues evident through this data analysis. (Please note the related requirements for inquiry reduction or prevention activities, as well as Activity 13006 Provider Telephone Inquiries)

B. Develop and operate programs to recruit and retain participating physicians and suppliers. Activities should address the needs of physicians and suppliers as indicated by your tracking initiatives, as well as coverage issues, reimbursement, medical necessity policies and billing requirements.

II. Advisory Groups

A. Establish a PET advisory group consisting of representatives from State medical societies, provider organizations, billing staffs and others. This body must be involved up front in the selection of topics, types and/or locations for educational forums. After coordinating with the carrier advisory committee (CAC), schedule regular briefings, at least quarterly, to determine which educational forums address the needs identified by your tracking initiatives, as well as specific informational requests as they are received.

B. Actively participates in those educational forums and professional gatherings that resulted from the discussions with, or recommendations of, the PET advisory group.

III. Bulletins

A. Issue regular bulletins/newsletters, at least quarterly, which contain program and billing information. Unless specifically requested by the provider, eliminate regular bulletins sent to providers with no billing activity in the previous twelve months. Send one bulletin addressed to the billing manager. If your prior practice and current operating budget permits it, contractors may send additional bulletins to individual providers/suppliers. All newly created bulletins must be posted on the contractor's website where duplicate copies may be obtained by provider/suppliers. In addition, if providers are interested in obtaining duplicate copies on a regular basis, contractors are permitted to bill providers for a yearly subscription of additional copies. All bulletins/newsletters must have either a header or footer that includes the following bolded

language "THIS BULLETIN SHOULD BE SHARED WITH ALL HEALTH CARE PRACTITIONERS AND MANAGERIAL MEMBERS OF THE PROVIDER/SUPPLIER STAFF. BULLETINS ISSUED AFTER OCTOBER 1, 1999 ARE AVAILABLE AT NO-COST FROM OUR WEBSITE AT (INSERT CONTRACTOR WEBSITE ADDRESS)"

B. Issue the regularly scheduled bulletins/newsletters approximately 45 **to 60** days in advance of standard systems releases. Provide print/distribution dates to your RO and CO contact in your PSP. Include deadline dates for the submission of articles in the event RO/Central Office staff wishes to incorporate specific information or articles.

C. Require providers and suppliers to "register" annually to receive hard copies of bulletins. Providers should also be encouraged to obtain copies from your web site or to subscribe to a ListServ to receive electronic copies of bulletins through the Internet. It will be assumed that providers/suppliers who do not obtain bulletins through either of these mechanisms do not wish to receive bulletins.

IV. Seminars/Workshops/Teleconferences

A. **Hold seminars or conferences or workshops or down-link/viewing sites** for Medicare Learning Network broadcasts and videos (and other face-to-face meetings) to educate providers regarding Medicare program and billing issues. Whenever feasible, you should coordinate these activities with other Medicare contractors in your service area (this may include PROs, other carriers or intermediaries, SHIP programs and ESRD Networks.) Whenever feasible, you should coordinate your activities with HCFA partners in your service area, such as State Survey and Certification Agencies, State Medicaid and CHIP programs, Area Health Education Centers, Geriatric Education Centers and State and local Health Departments. Contractors are no longer permitted to charge providers to recoup the costs associated with this type of activity.

B. Hold teleconferences to address and resolve inquiries from providers, as a method to maximize the number of providers reached.

V. New Technologies/Electronic Media

A. Implement new technologies (e.g., Internet websites) and other electronic means of educating and training providers. The development of websites, Internet applications, etc. should follow HCFA Standards and Guidelines. Your website must comply with HCFA=s AContractor Website Standards and Guidelines≅ posted at http://www.hcfa.gov/about/web/contrsng.htm. In addition, the features and contents of these websites must be tested for compatibility with multiple browsers and comply with the following requirements:

Content

In FY 2001, your website must contain the following:

- All newly created provider bulletins/newsletters; A schedule of upcoming events (seminars/workshops, fairs, etc);
- An ability to register for seminars and other events via the website;
- Features which permit providers to order and receive copies of bulletins;
- An area designated as the Medicare Learning Network. This area will contain the graphical representation for the Network and program and promotional material supplied by HCFA. This material will be made available to you periodically at http://www.hcfa.gov/other/bestpractices/default.htm (the Best Practices site for carrier and intermediary PM-PET staff). This area should also include links to http://www.hcfa.gov/medlearn/ , http://www.hcfa.gov/pubforms/pubpti.htm (the site for downloading HCFA manuals and

transmittals, as well as links (that you will need to identify and create) to HCFA contractors and partners); and

- A **quarterly** listing of frequently asked questions(FAQs/areas of concern as shown through inquiry and data analysis.

Your website should fit into your existing infrastructure. Existing resources and technologies should be utilized wherever possible to reduce costs.

If possible, your provider outreach website should be established as a SUBDOMAIN of your current commercial website. A subdomain is defined as a unique, separate segment of your current website devoted specifically to one topic (in this case, Medicare provider outreach). The website should neither be on its own separate web server/URL, nor should it be completely integrated with your commercial content. An example of a HCFA-implemented subdomain is http://www.hcfa.gov/hiv/. While this website is located on the cms.hhs.gov servers and maintained by the same staff, they have a different look and feel and unique content. Great economies of scale are achieved by sharing resources such as bandwidth, functionality (e.g., search engines), and staff.

Your website must implement the following technologies to support use of the site:

- Search engine functionality;
- E-mail based support / help / customer service; and
- An ability to link to other sites such as www.hcfa.gov and www.medicare.gov.

In addition, you may want to offer e-mail based mailing lists (listservs) that users can subscribe to for promotion of new content, initiatives, etc.

If you have questions relating to content and funding issues, please contact Jackie Proctor at (410) 786-9019 / Jproctor2@cms.hhs.gov. Direct questions regarding technical requirements to Jon Booth at (410) 786-6577 / Jbooth2@cms.hhs.gov or Tim Walsh at (410) 786-7425 / Twalsh3@cms.hhs.gov.

B. At least, query the Best Practices site available at http://www.hcfa.gov/other/bestpractices/default.htm determine which educational practices are adaptable for their organization and identify material for their Medicare Learning Network sub-domain or bulletins.

C. Use of CPT codes on websites must adhere to the following requirements:

- CPT codes and long descriptions can be used on Contractors' Web Sites as long as the publication does not contain more than 30 percent of a section or subsection of the CPT. If more than 30 percent of a section or subsection of CPT is used, then the contractor's codes and long descriptions must be integrated into narrative text. Of course, contractors are permitted to use CPT codes and CPT code ranges (no long descriptions) without applying the 30 percent. This restriction does not apply to printed material. It only applies to the content of your website, including any video products. Since the restrictions apply to electronic, but not print material, you may need to review and revise any print material when it is posted to your website.

- The 30 percent restriction on use of CPT long descriptions does not apply if the subsection of the CPT has fewer than 30 codes.

- No more than 30 percent of the CPT long descriptions may be used for the Anesthesia, Evaluation and Management, and the Pathology and Laboratory sections of CPT for each use (first level section of the heading in the CPT book). The 30 percent subsection limitation is waived for these categories.

- The AMA copyright must be displayed on the first screen or web page of any CPT, where any CPT is used in publications on the Internet websites and in other electronic media, whether short or long descriptions are used, or only codes or ranges. The copyright notice is:

  "CPT codes, descriptions and other data only are copyright 1999American Medical Association (or such other date of publication of CPT). All rights reserved. Applicable FARS/DFARS apply."

- Contractor Web sites should be designed so that site visitors must acknowledge the terms of the AMA copyright prior to accessing any proprietary CPT material.

- Contractors must use the point and click license before initial access to any CPT containing HTML pages or prior to each document containing CPT and before each download containing CPT. A statement must also appear on the post-point and click download pages as per http://www.hcfa.gov/stats/revdnlod.htm .

- Contractors must use the point and click license on computer-based training modules that function as software and contain CPT codes.

- Contractors must include a shrink wrap license in electronic media containing CPT information that is to be distributed to users outside of their organization. This license need not literally involve "shrink wrap" material rather at a minimum require the user to break a seal (e.g., paper label) to acknowledge acceptance of the terms of the license. The following notice must appear in boldface type in a conspicuous location so that it can be seen prior to opening the media package distributed by the user outside of the contractor:

  "Carefully read the following terms and conditions before opening the Electronic Media Package. Opening this package acknowledges your acceptance of these terms and conditions. If you do not agree with these provisions, you should, within a reasonable time, return the Electronic Media Package unused."

- Bulletins and newsletters posted on the web sites prior to October 1, 2000 need not comply with these instructions as long as the applicable copyright notice is displayed.

- After October 1, 2000, Local Medical Review Policies (LMRPs) posted on the websites that are newly issued or revised must conform to these instructions. (This requirement will be included in MIP activities)

- LMRPs and other non-archival publications posted on the web sites prior to October 1, 2000 must conform to these instructions on later than October 1, 2001. (This requirement will be included in MIP activities)

D. Conduct training for provider staff in electronic claims submission including but not limited to activities listed in Productivity Investments; use of Medicare billing and PC-Print software; use of available Medicare EDI transactions; use of new or updated Medicare software released during the year; use of newly introduced EDI standards and/or functions or changes to existing standards or functions.

NOTE: There are multiple sources of funding associated with EDI functions. Please pay particular attention to the notes below to ensure that costs are being attributed to the appropriate activity code.

* The education of providers on the impact of operation of version 4010 of the ASC X12 standards for the 270/271, 275 (attachments), 276/277,835, and 837 transactions for HIPAA, and share transaction specification information

with providers and their clearinghouses should be billed to Productivity Investments. (The 835 and 837 formats will be updated to version 4010 as part of the annual update under Bills Payment.)

* The PM-PET function covers the education of providers in group settings rather than contact with individuals. PM-PET costs include newsletters, classes or outreach to groups of providers and their staff on Medicare coverage, billing and benefits of EDI. This does not include costs related to connectivity for individual providers or the resolution of connectivity problems. Similarly, EDI transactions, or interactions with vendors/clearinghouse for the transfer of EDI transactions are not PM-PET costs. EDI specific support is generally supplied by EDI staff but may vary by contractor. If PET-staff also furnish specialized EDI support, the proportion of their time spent furnishing EDI support to individual providers should be charged to Bills Payment.

VI. Internal Staff Development

A. Develop open communications with all staff in your organization (including medical review, EDI/Systems and program integrity staff) to ensure that inquiries and shared issues raised by providers are resolved. Encourage participation in provider training related to their areas.

B. Establish a plan to strengthen the quality of written and verbal correspondence with providers/suppliers. Your plan should include an internal review process and activities to ensure that the quality of your communications is continuously improving. (Please note the related requirements for inquiry reduction or prevention activities, as well as Activity 13006 Provider Telephone Inquiries.)

C. Develop open communication with staff at all levels in your organization to encourage the development of creative ideas for improving service to providers/suppliers and to the Medicare program in general. All staff should be encouraged to feed upper management their ideas and suggestions for cost effective improvements to provider service. An internal process should be in place whereby improvement ideas are acknowledged and considered. Those ideas deemed unique and cost effective should be included in the Quarterly PSP reports sent to your RO and CO staff. Selected reports will be posted on: http://www.hcfa.gov/other/bestpractices/default.htm and may be selected for national implementation.

D. Implement a developmental plan for training new provider service staff and periodically assessing and training existing staff. Part of the assessment should include random monitoring of calls for accuracy and courtesy. (Note the related requirements for inquiry reduction or prevention activities, as well as Activity 13006 Provider Telephone Inquiries.)

VII. Telephone Inquiries

A. Develop and implement inquiry reduction and prevention activities that are designed to reduce the number of telephone calls for specific high-volume issues. (Please note the related requirements for inquiry reduction and prevention activities, as well as Activity 13006 Provider Telephone Inquiries.) At least quarterly, contractors should query the Best Practices site available at http://www.hcfa.gov/other/bestpractices/default.htm to determine which educational practices are adaptable for their organization.

VIII. Responsiveness to OIG/GAO Findings

A. Where possible, incorporate materials that clearly delineate the physician's role in the creation, certification and recertification of the plan of care for home health, and the beneficiary need for partial hospitalization into existing educational activities.

IX. Provider Specific Educational Activities

A. Perform specialized activities, such as workshops and bulletins, to educate providers concerning the

physician fee schedule.

B. Inform providers, especially physicians, of the physician certification requirements for ambulance services.

X. Submission of Quarterly Report Activities.

Outlined below are the specific dates, format and content requirements for the PSP quarterly reports. Plans and quarterly reports sent to Central Office should be addressed to: Center for Health Plans and Providers, Division of Provider Education and Training, Mailstop C4-10-07, 7500 Security Boulevard, Baltimore, Maryland 21244. For ease of review, contractors are requested to provide a narrative summary of activities as well as annotate quantifiable information in a table or spreadsheet format. Please submit this information in chronological order and include a point of contact for each quarterly report.

A. Due Dates:

- Quarterly Activity Reports are used to recount provider education efforts or activities that occurred or were planned during the preceding quarter. Quarterly Reports are due January 31, 2001 (First Quarter), April 30, 2001 (Second quarter), July 31, 2001 (Third quarter) and October 31, 2001 (Fourth quarter).

B. Format and Content:

- The Quarterly Reports are designed to provide a summary of the quarter's provider education efforts and cite significant activities or accomplishments that occurred. Contractors are asked to include a summary of the most frequently asked questions and areas of concern, and problem areas as determined by claim submission errors and inquiries. Please identify how these areas were, (or will be), addressed by the activities conducted during the previous quarter.

- Please include the date, subject matter, size of audience and location(s) (if applicable), of educational activities conducted through:

  1) Publications - Report on regular bulletins, special bulletins or publications that contain provider education materials.

  2) Seminars/Conventions/Workshops - Report on all significant events (workshops, conferences, health fairs, down-links, etc.) that either fully or partially promoted provider education and in which contractor staff was directly involved.

  3) Training Provider Staff on Billing and/or Program Issues.

  4) Briefings and Meetings with State Medical Societies and Provider Organizations (including the PET advisory group).

  5) Teleconferences.

  6) Electronic and Video -Report on significant electronic (Internet, bulletin boards, computer-based training, etc.) and video media efforts involving the dissemination of provider education material.

XI. Other

A. Coordinate with Durable Medical Equipment (DME) Regional Carriers on issues affecting DME suppliers.

B. Actively solicit feedback related to the Medicare program and contractor service at every opportunity, e.g., tear-off replies in newsletters, feedback sessions at meetings, etc.

C. Promote utilization of preventive benefits as specified in the Balanced Budget Act of 1997.

D. Develop and implement an effectiveness measure for each educational or training activity. This includes, but is not limited to, such things as customer satisfaction survey instruments, and pre and post-testing at meetings and seminars.

E. Exercise your capacity to analyze physician/supplier problems and issues and identify and resolve common policy and systems issues.

DISCRETIONARY PROVIDER EDUCATION ACTIVITIES

1. Issuance of special bulletins or letters which contain program and billing information. Unless specifically requested by the provider or supplier, eliminate issuance of these items to all providers and suppliers with no billing activity in the prior twelve months. Send one bulletin for each provider number, which includes each group number and each individual number within the group. Send one bulletin addressed to the billing manager.

2. Participate in other Medicare contractor conferences on program and billing Issues that did not result from recommendations of the PET advisory group.

3. Presentations at Non-Medicare contractor conferences.

4. Preparation of videos.

5. Issue advisories from the Medical Director to area physicians.

6. Request provider feedback on the effectiveness of Audio Response Units (ARUs). Utilize feedback to make improvements t the ARU system.

FY 2001 BUDGET AND PERFORMANCE REQUIREMENTS
PROGRAM MANAGEMENT
Addendum 2

Participating Physician (Carrier)

Funding for the continuation of the Annual Participating Enrollment, Limiting Charge Monitoring Activities and Dissemination of Participation Information remains a priority for HCFA for the 2001 fiscal year. All of these activities remain vital functions to the operating efficiency of this agency. **(Use Activity Code 15001)**

- **Annual Participation Enrollment**

- Print and mail calendar year 2001 participation enrollment packages (consisting of the "Dear Doctor" Announcement, Blank Par Agreement, Fact Sheet and physician fee schedule hardcopy disclosure report) via first class or equivalent mail delivery service. Send one disclosure report to group practices. Upon request, additional disclosure reports may be furnished to groups or individuals at cost;

- Process participation enrollments and withdrawals;

- Furnish participation data to RRB (MCM 7552); and

- Furnish participation data to HCFA (MCM 13421ff).

- **Limiting Charge Monitoring Activities**

- Investigate/develop beneficiary-initiated limiting charge violation complaints;

- Assist in obtaining overcharge refunds for beneficiaries who request your assistance;

- Respond to limiting charge inquiries from non-participating physicians;

- Internally produce and store limiting charge reports (e.g., LCERs/LCMRs); and

- Submit quarterly reports for internally produced limiting charge reports (MCM 13326ff).

- Do not send Limiting Charge Exception Reports (LCERs) to providers;

- Do not send Limiting Charge Management Reports (LCMRs) to providers;

- Do not perform routine refund verification activities (i.e., no beneficiary complaint or request for assistance is involved);

- Do not perform routine limiting charge cases (i.e., only pursue cases in which the beneficiary has requested your assistance).

- **Dissemination of Participation Information**

- Furnish customized participation information (either by phone or in writing) in response to requests for such information;

- Discontinue the production and mass distribution of hardcopy MEDPARD directories;

- Load MEDPARD information on your Internet website and inform physicians, practitioners, suppliers, hospitals, Social Security Offices, Congressional Offices, PROs, senior citizens groups and State area agencies of the Administration on Aging how to access this website information.

FY 2001 BUDGET AND PERFORMANCE REQUIREMENTS
PROGRAM MANAGEMENT
Addendum 2

Productivity Investments (Carrier)

Note: The following is provided for carrier information and planning purposes only. Do not request funding for these projects unless specifically requested to do so. Funding will be distributed or Supplemental Budget Requests solicited when appropriate.

ELECTRONIC DATA INTERCHANGE (EDI)

See the definition of EDI in the claims payment section. This section designates those activities that we expect to fund as PIs in FY 2001. Specific details and requirements will be included in the implementation instructions upon release.

Standards Activities

- Support by selected contractors appointed by HCFA for FY2001 to participate in standards organization workgroups for development, maintenance, review and publication of electronic transaction standards.

- Support by selected contractors appointed by HCFA for FY 2001 to test the attachments standard.

- Make system changes to implement version 4010 of the X12 270/271 and 276/277 standards to comply with HIPAA requirements. (The 835 and 837 formats will be updated to version 4010 as part of the annual update discussed under Claims Payment, but additional provider testing required due to this update will be separately funded through SBRs.) Conduct system compatibility testing with providers and clearinghouses on the implemented HIPAA standard transactions.

- Furnish free/at cost Medicare HIPAA compliant billing and PC-Print remittance advice software to providers on request. Rather than individually and independently develop HIPAA-compliant billing and PC-Print software, however, carriers will be strongly encouraged to obtain software already developed by or for another carrier, or to partner with other carriers to obtain HIPAA version billing and PC-Print software.

- Educate Medicare providers on the impact of operation of version 4010 of the ASC X12 standards for the 270/271, 275 (attachments), 276/277, 835, and 837 transactions for HIPAA, and share transaction specification information with providers and their clearinghouses so they can make necessary system changes.

- DMERCs must implement X12 version 4010 standards for the 270/271, 276/277, 278, 835, 837, and National Council of Prescription Drug Plan formats to comply with HIPAA, and furnish provider education as needed to retain or increase usage of EDI in conjunction with this transition. DMERCs will transition to X12 formats from the NSF in FY 2001.

- Support from selected contractor appointed by HCFA for FY 2001 to conduct a quality review of overall carrier and DMERC progress implementing the HIPAA transaction standards.

SYSTEMS SECURITY

HCFA will issue new system security requirements by September 30, 2000.

Required Activities:

- Designate a Medicare Systems Security Coordinator.

- Prepare a comprehensive system security plan based on the forthcoming requirements which addresses: security risk assessment; administrative procedures; physical safeguards; technical services to protect data at rest and; technical mechanisms to protect data in transit. The plan must include remote or contracted facilities e.g., data centers, where Medicare functions are performed or Medicare data is stored and, a senior management certification that the security plan conforms to HCFA requirements.

- Develop a contingency plan designed to recover operations following security attacks or failures. Conduct a test of your contingency plan to assess your organization's capability for executing it.

HCFA and its Independent Verification and Validation contractor (IV&V) will assess each Medicare contractor security plan. Findings may be incorporated in the FY 2001 Contractor Performance Evaluation (CPE).

Discretionary Activities:

- Use the services of independent information system security consultants to: conduct risk assessments; prepare or evaluate security plans; to plan or evaluate contingency plan drills.

- Conduct information security technical training for it IT staff and security awareness training for its other employees.

- Acquire hardware and software, as necessary, to address risks identified in the security plan.

- Participate in HCFA- sponsored and/or health care industry best practice forums on information security.

CLINICAL DIAGNOSTIC LABORATORY SERVICES

As a result of a Negotiated Rule Making for Clinical Diagnostic Laboratory Claims new claims processing requirements will be implemented. All carriers will be required to implement these new claims processing requirements effective October 1, 2001 (FY 2002). These changes must be accomplished during the fourth quarter of FY 2001. The bill process must be adapted to accommodate the transition, which may include changes to local contractor-controlled claims processing systems and related functions.

Training will be necessary in FY 2001 in order to implement effectively the new requirements. Because the rule has not been published, only examples of new requirements can be provided at this time. The new requirements may include; new and clarified documentation and record keeping requirements, new claims processing requirements, and a new definition of date of service. Details on the specifics of what should be covered will be provided later through a program memorandum. This training can be accomplished using bulletins, web page information, training sessions to ensure an effective implementation.

AMBULANCE RULE MAKING

All carriers will be required to transition to the new fee schedule over a three-year period. During this three-year period the carriers will be required to maintain the ability to continue to pay claims on a reasonable charge basis. The payment amount will be blended with the fee schedule provided by HCFA CO over a three year period. The fourth year payment will be based wholly on the fee schedule . The claims process must be adapted to accommodate the transition and the new fee schedule methodology, which may include changes to local contractor-controlled claims processing systems and related functions.

Carriers will be required to provide education for providers (e.g., bulletins, web page information, training sessions) to ensure an effective transition from reasonable cost reimbursement methodology to a fee schedule.

MEDICARE SUMMARY NOTICE

HCFA will continue implementation efforts associated with the Medicare Summary Notice (MSN) for Medicare contractors. This process requires system changes and the development of an outreach plan for educating the beneficiary and provider communities, and other external entities that may be affected by the issuance of the MSN, such as State Health Insurance Assistance Programs, Peer Review Organizations, etc.

If the contractor has not yet implemented the MSN, the contractor will be identified and notified by HCFA's Customer and Teleservice Operations Group. If the contractor is identified for implementation, it will need to make the necessary system changes and conduct outreach activities in a timely manner. Contractors who have not yet implemented the MSN but are identified for implementation in FY 2001 must submit an outreach plan to the appropriate regional office prior to conducting any outreach activities related to MSN implementation. These contractors should begin outreach activities 90 days prior to the implementation date.

HEALTH PLAN IDENTIFIER (PlanID)

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires the Secretary to adopt unique standards for individuals, employers, health plans, and health care providers for use in electronic health care transactions. Based on this requirement, HCFA plans to publish a Notice of Proposed Rule Making (NPRM) in July 2000 and a final rule in July 2001 in the Federal Register proposing that the PlanID (formerly known as PAYERID) be adopted as the national health plan identifier. The purpose of publishing the NPRM and final rule is to seek additional comments on HCFA's proposed enumerator for health plans and to mandate its use on all electronic transactions specified in HIPAA.

If the PlanID is adopted as the standard by the Secretary, FIs will be required to make changes to their existing systems to send and accept health care transactions with the new standards (PlanID) in lieu of the current alpha-numeric representation of health plans. Final instructions will be issued by February 2001 with a July 1, 2001, implementation date.

NATIONAL PROVIDER SYSTEM

Shared system maintainers' and contractors' activities regarding initial implementation of the National Provider System (NPS) and conducting the test enumeration of all existing Medicare providers. Funding for contractors' activities include provider training and education (sending newsletters and bulletins), using the NPS Standard Record Format, and supporting the test enumeration of all existing Medicare providers. Additional contractor activities will be exploring the use of the NPI in claims processing as well as developing other administrative tasks associated with distributing these unique identifiers (e.g., validating eligibility, communicating with NPS, producing electronic and hardcopy directories, mailings, staffing, etc.).

CONTRACTOR TESTING REQUIREMENTS –(ACTIVITY CODE 17022)

The HCFA FY 2001 Operating Plan provides for no additional funding for Medicare contractors to comply with the systems directives described in Program Memorandum (PM) AB-00-25. We are working with a group of contractors to revise the testing requirements in the PM to allow testing to continue within the available budget.